



Tiny Learning Services

Intake Form

Client Name:

Age:

Parent/Guardian:

Emergency Contact Information

Name:

Phone #:

Area of Need

Service Needed (can check all that apply):

☐ Learning Coaching/Skill Development

☐ Transition Planning/Support

☐ Tutoring

Please Specify:

Skill or subjects in need of support:

Scheduling

Weekly Availability:

☐ Monday

☐ Tuesday

☐ Wednesday

☐ Thursday

☐ Friday

Times Available: _____ or _____ or _____

Start Date: _____

Additional Information

Medical and/or Mental Health Needs

Please describe (if relevant):

Diagnosis (if applicable):

Type of Schooling:

☐ Elementary

☐ Secondary

☐ Post-secondary

Program _____

☐ College

☐ University

This information is confidential, thank you